New Jersey Department of Health and Senior Services
Health Insurance Continuation Program
P O Box 363
Trenton, NJ 08625-0363

FOR STATE USE ONLY
Record #

AUTHORIZATION/RELEASE OF INFORMATION

Name of Applicant (Patient)	Social Security Number
Street Address	
City, State, Zip Code	

I authorize the release of information necessary to determine my eligibility for the Health Insurance Continuation Program from records in possession of the Social Security Administration, Internal Revenue Service, the New Jersey Division of Taxation, my employers, bank and health insurance company, Social Service agencies, hospitals and other medical facilities where I have received care and treatment, and others as the need arises.

I authorize my physician to release all requested information concerning all my medical conditions to the New Jersey Department of Health and Senior Services, Health Insurance Continuation Program and Surveillance Unit.

I further authorize the New Jersey Department of Health and Senior Services to receive and disclose pertinent medical and personal information to determine my continued eligibility for the Health Insurance Continuation Program and to make arrangements for payments on my behalf. Arrangements may include contacting above mentioned agencies, my case manager/social worker and physician, to obtain information necessary to provide health insurance continuation and to obtain information and cost on services provided. In addition this information may be disclosed to the Department of Health and Senior Services as needed to facilitate provision of medical services, medical supplies or pharmaceuticals.

I authorize the New Jersey Department of Health and Senior Services, HICP to receive all my premium (billing) notices and any refunds for premium payments, made by them on my behalf, due to cancellation or overpayment of my policy.

Signature of Applicant (Patient) or Guardian	Date
Signature of Spouse, if Married	Date
Name of Witness (Print)	
Signature of Witness	Date

Applicant: Forward this completed Authorization/Release of Information form to the Health Insurance Continuation Program, along with your Application.